DEPARTMENT OF THE ARMY
NONAPPROPRIATED FUNDS

CERTIFICATE OF MEDICAL EXAMINATION

(Applicant must supply information below to heavy line)
(Typewrite or Print in Ink)

For use of this form, see AR 215-3; the proponent agency is DCS, G1.

1. NAME *(CAPS)* LAST - FIRST - MIDDLE MR. - MISS - MRS.	2. SEX ☐ MALE ☐ FEMALE	3. BIRTH DATE *(Mo., day, year)*	4. SOCIAL SECURITY NO.
5. STREET ADDRESS AND APARTMENT NO.	6. CITY, STATE, AND ZIP CODE		
7. POSITION TITLE AND NUMBER	8. PAY PLAN AND OCCUPATION CODE	9. GRADE OR LEVEL	10. SALARY
11. NAME AND LOCATION OF EMPLOYING OFFICE			

12. (A) ARE YOU NOW EMPLOYED IN POSITION SHOWN IN ITEM 7 ☐ YES ☐ NO	(B) IF "YES" GIVE THE DATE OF YOUR ORIGINAL APPOINTMENT TO THIS POSITION:

13. (A) HAVE YOU ANY PHYSICAL DEFECT OR DISABILITY WHATSOEVER? ☐ YES ☐ NO IF "YES", GIVE DETAILS.

(B) DOES THE VETERANS ADMINISTRATION RECOGNIZE SERVICE-CONNECTED DISABILITY IN YOUR CASE? ☐ YES ☐ NO

(C) HAVE YOU EVER RECEIVED DISABILITY RETIREMENT FROM THE U.S. CIVIL SERVICE COMMISSION OR A NONAPPROPRIATED FUND ACTIVITY? ☐ YES ☐ NO

Sign your name in INK as it appears on your application in the presence of the physician for purpose of identification.	SIGNATURE OF APPLICANT

DOCTOR: All questions on both sides of this certificate and on the lower half of the attached Health Qualification Placement Record must be answered. Before beginning the examination, refer to items 13 and 14 on the Health Qualification Placement Record so that you will have a knowledge of the physical requirements of the position to which the applicant is to be appointed. Sign both this certificate and the Health Qualification Placement Record

1. HEIGHT:_____ FEET_____ INCHES WEIGHT:_____ POUNDS

2. EYES:

	20	20	20	20
(A) DISTANT VISION *(Snellen):*	WITHOUT GLASSES: RIGHT	LEFT	WITH GLASSES, IF WORN: RIGHT	LEFT

(B) WHAT IS THE LONGEST AND SHORTEST DISTANCE AT WHICH THE FOLLOWING SPECIMEN OF JAEGER NO. 2 TYPE CAN BE READ BY THE APPLICANT? TEST EACH EYE SEPARATELY.

	WITHOUT GLASSES:	WITH GLASSES, IF WORN:
	R._____ IN. TO_____ IN.	R._____ IN. TO_____ IN.
	L._____ IN. TO_____ IN.	L._____ IN. TO_____ IN.

(C) EVIDENCE OF DISEASE OR INJURY: RIGHT _____ LEFT_____

(D) COLOR VISION: IS COLOR VISION NORMAL WHEN ISHIHARA OR OTHER COLOR PLATE TEST IS USED? ☐ YES ☐ NO
IF NOT, CAN APPLICANT PASS LANTERN, YARN, OR OTHER COMPARABLE TEST? ☐ YES ☐ NO

3. EARS: (CONSIDER DENOMINATORS INDICATED HERE AS NORMAL. RECORD AS NUMERATORS THE GREATEST DISTANCE HEARD)
ORDINARY CONVERSATION:
RIGHT EAR_____ LEFT EAR_____ EVIDENCE OF DISEASE OR INJURY: RIGHT EAR _____ LEFT EAR_____
20 FT. 20 FT.

4. NOSE	5. PARA NASAL SINUSES	6. MOUTH AND THROAT

7. GASTRO-INTESTINAL	(A) HISTORY OF PEPTIC ULCER: ☐ YES ☐ NO IF "YES", IS ULCER: ☐ ACTIVE ☐ QUIESCENT ☐ HEALED HOW LONG?_____ DATE OF LAST X-RAY_____ SYMPTOMS PRESENT, IF ANY *(Severity, frequency, etc.):* TREATMENT *(Use space under "Remarks," if needed):*

8. METABOLIC DISORDERS: (INDICATE ANY ABNORMALITY OF THE FOLLOWING GLANDS BY A CHECK IN THE APPROPRIATE BOX, AND EXPLAIN UNDER "REMARKS.")
☐ THYROID ☐ PANCREAS ☐ PITUITARY ☐ OVARIAN

9. HEART AND BLOOD VESSELS

(A) BLOOD PRESSURE: MM. HG. SYSTOLIC _____ DIASTOLIC

(B) IS ORGANIC HEART DISEASE PRESENT? ☐ YES ☐ NO

(C) IF ORGANIC HEART DISEASE IS PRESENT, IS IT FULLY COMPENSATED? ☐ YES ☐ NO

(D) PULSE RATE:
SITTING_____ IMMEDIATELY AFTER EXERCISE (UNLESS CONTRAINDICATED) _____
TWO MINUTES AFTER EXERCISE _____ CARDIAC RESERVE _____
(GOOD, FAIR, OR POOR)

10. LUNGS:

RIGHT_____ LEFT _____

HISTORY OF TUBERCULOSIS? ☐ YES ☐ NO. IF "YES", HOW LONG HAS THE DISEASE BEEN ARRESTED?

IF THERE IS HISTORY OF TUBERCULOSIS, IS ANY TYPE OF COLLAPSE THERAPY BEING RECEIVED AT PRESENT? ☐ YES ☐ NO. IF "YES," GIVE FULL DETAILS UNDER "REMARKS." IS MEDICAL SUPERVISION NECESSARY? ☐ YES ☐ NO

(IF X-RAY IS MADE, GIVE REPORT UNDER "REMARKS.")

11. HERNIA: ☐ YES ☐ NO. IF "YES", NAME VARIETY: INGUINAL, VENTRAL, FEMORAL, POST-OPERATIVE, ETC.:
IF PRESENT, IS IT SUPPORTED BY A WELL-FITTING TRUSS? ☐ YES ☐ NO

12. VARICOSE VEINS: ☐ YES ☐ NO. IF "YES", STATE LOCATION AND DEGREE.

13. FEET: IS FLAT FOOT PRESENT? ☐ YES ☐ NO. IF "YES", STATE DEGREE OF IMPAIRMENT OF FUNCTION _____
(NONE, SLIGHT, MODERATE, SEVERE)

14. DEFORMITIES, ATROPHIES, AND OTHER ABNORMALITIES, DISEASE NOT INCLUDED ABOVE

15. SCARS OF SERIOUS INJURY OR DISEASE

16. NERVOUS SYSTEM: (A) INCLUDE SYMPTOMS AND FULL HISTORY OF ANY MENTAL, NERVOUS OR EMOTIONAL ABNORMALITY (USE ADDITIONAL SHEETS IF NECESSARY.):

(B) HAS APPLICANT EVER BEEN HOSPITALIZED OR TREATED FOR A MENTAL ILLNESS? ☐ YES ☐ NO

(C) WHERE (NAME AND LOCATION OF HOSPITAL):

(D) DATE OR DATES OF HOSPITALIZATION:

(E) DESCRIBE ANY RESIDUALS OF PREVIOUS MENTAL OR NERVOUS ILLNESS:

(F) ANY HISTORY OF EPILEPSY OR FAINTING SPELLS? ☐ YES ☐ NO. IF SO, GIVE DETAILS UNDER "REMARKS" BELOW.

17. EVIDENCE OR HISTORY OF VENEREAL DISEASE: IF BLOOD SEROLOGY OR OTHER LABORATORY EXAMINATIONS ARE MADE, GIVE DETAILS UNDER "REMARKS."

18. URINALYSIS (IF INDICATED):
SP. GR _____ ALBUMEN _____ SUGAR _____
CASTS _____ BLOOD _____ PUS _____

I HAVE FOUND THE APPLICANT ABNORMAL UNDER THE FOLLOWING HEADINGS:

REMARKS:

19. SIGNATURE OF PHYSICIAN OR EXAMINER	NAME TYPED OR PRINTED	DATE

20. ADDRESS OF EXAMINING PHYSICIAN *(Typed or printed)*

21. DO YOU HAVE FEDERAL DESIGNATION? ☐ YES ☐ NO
IF "YES," SPECIFY
☐ FULL TIME ☐ PART TIME ☐ FEE BASIS

HEALTH QUALIFICATION PLACEMENT RECORD
(NONAPPROPRIATED FUNDS)

1. NAME *(CAPS)* LAST - FIRST - MIDDLE MR. - MISS - MRS.	2. SEX ☐ MALE ☐ FEMALE	3. BIRTH DATE *(Mo., day, year)*	4. SOCIAL SECURITY NO.
5. STREET ADDRESS AND APARTMENT NO.	6. CITY, STATE, AND ZIP CODE		
7. POSITION TITLE AND NUMBER	8. PAY PLAN AND OCCUPATION CODE	9. GRADE OR LEVEL	10. SALARY
11. NAME AND LOCATION OF EMPLOYING OFFICE			
12. (A) ARE YOU NOW EMPLOYED IN POSITION SHOWN IN ITEM 7 ☐ YES ☐ NO	(B) IF "YES" GIVE THE DATE OF YOUR ORIGINAL APPOINTMENT TO THIS POSITION:		

TO BE COMPLETED BY APPOINTING OFFICER: SECTIONS 13 AND 14

(A). BRIEF OUTLINE OF WHAT WORKER DOES
For the physician's use, set down in brief and simple terms what the employee does on this job, including environmental details such as stairs to climb, distance to rest room facilities, cafeteria, work- shift, etc. *(Use Section 13 below.)*

(B). PHYSICAL DEMANDS OF THE POSITION
In Section 14 below, encircle the number of those factors which are essential to the duties of the position for which this applicant is being considered. The blank spaces may be used for special factors not listed.

13. TITLE OF POSITION AND OUTLINE OF WHAT WORKER DOES IN THIS POSITION *(Advise use of dictionary of occupational titles as guide, as applicable)*

TO BE COMPLETED BY EXAMINING PHYSICIAN: SECTIONS 14 THROUGH 20

INSTRUCTIONS: The items circled below indicate the physical requirements of the position for which this individual is being considered. Indicate the individual's physical capacities for this position by placing an X in the appropriate column opposite the numbers encircled. If the individual has any other physical limitations relating to physical requirements not encircled or not covered by this form, indicate these under **"Remarks"** on the reverse side. Whenever PARTIAL capacity has been indicated, explain under **"Remarks,"** giving specific quantities.

14. PHYSICAL REQUIREMENTS

	CAPACITY			ENVIRONMENTAL FACTORS	CAPACITY		
	FULL	PARTIAL	NONE		FULL	PARTIAL	NONE
1. OUTSIDE				18. WORKING AROUND MACHINERY WITH MOVING PARTS			
2. OUTSIDE AND INSIDE				19. MOVING OBJECTS OR VEHICLES			
3. EXCESSIVE HEAT				20. WORKING ON LADDERS OR SCAFFOLDING			
4. EXCESSIVE COLD				21. WORKING BELOW GROUND			
5. EXCESSIVE HUMIDITY				22. UNUSUAL FATIGUE FACTORS *(Specify)*			
6. EXCESSIVE DAMPNESS OR CHILLING							
7. DRY ATMOSPHERIC CONDITIONS				23. WORKING WITH HANDS IN WATER			
8. EXCESSIVE NOISE, INTERMITTENT				24. EXPLOSIVES			
9. CONSTANT NOISE				25. VIBRATION			
10. DUST				26. WORKING CLOSELY WITH OTHERS			
11. SILICA, ASBESTOS, ETC.				27. WORKS ALONE			
12. FUMES, SMOKE, OR GASES				28. PROTRACTED OR IRREGULAR HOURS OF WORK			
13. SOLVENTS *(Degreasing agents)*				29. SPECIAL FACTORS *(Specify)*			
14. GREASES AND OILS							
15. RADIANT ENERGY							
16. ELECTRICAL ENERGY							
17. SLIPPERY OR UNEVEN WALKING SURFACES							

14. PHYSICAL REQUIREMENTS (Continued) FUNCTIONAL FACTORS

	CAPACITY				CAPACITY		
	FULL	PARTIAL	NONE		FULL	PARTIAL	NONE
33. HEAVY LIFTING - 45 POUNDS AND OVER				54. ABILITY FOR RAPID MENTAL AND MUSCULAR COORDINATION SIMULTANEOUSLY			
34. MODERATE LIFTING - 15-44 POUNDS							
35. LIGHT LIFTING - UNDER 15 POUNDS				55. ABILITY TO USE AND DESIRABILITY OF USING FIREARMS			
36. HEAVY CARRYING - 45 POUNDS AND OVER							
37. MODERATE CARRYING - 15-44 POUNDS				56. NEAR VISION CORRECTIBLE AT 13 TO 16 INCHES TO *(Jaeger 1 to 4)*			
38. LIGHT CARRYING - UNDER 15 POUNDS							
39. STRAIGHT PULLING (HOURS)				57. FAR VISION CORRECTIBLE TO 20/20 TO 20/40			
40. PULLING - HAND OVER HAND (HOURS)				58. FAR VISION CORRECTIBLE TO 20/50 TO 20/100			
41. PUSHING (HOURS)				59. SPECIFIC VISUAL REQUIREMENT *(Specify)*			
42. REACHING ABOVE SHOULDER							
43. USE OF FINGERS				60. BOTH EYES REQUIRED			
44. BOTH HANDS REQUIRED				61. DEPTH PERCEPTION			
45. WALKING (HOURS)				62. ABILITY TO DISTINGUISH BASIC COLORS			
46. STANDING (HOURS)				63. ABILITY TO DISTINGUISH SHADES OF COLORS			
47. CRAWLING (HOURS)				64. HEARING *(Aid permitted)*			
48. KNEELING (HOURS)				65. HEARING WITHOUT AID			
49. REPEATED BENDING (HOURS)				66. SPECIFIC HEARING REQUIREMENTS *(Specify)*			
50. CLIMBING - LEGS ONLY (HOURS)							
51. CLIMBING - USE OF LEGS AND ARMS				67.			
52. BOTH LEGS REQUIRED				68.			
53. OPERATION OF CRANE, TRUCK, TUG, TRACTOR, OR MOTOR VEHICLE				69.			
				70.			

15. THIS PERSON SHOULD USE: (A) PROPERLY FITTED EYEGLASSES ☐ **(B) PROPERLY FITTED HEARING AID** ☐
(C) OTHER PROSTHETIC AID *(Specify)* ☐

16. REMARKS AND RECOMMENDATIONS:

17. PHYSICAL HANDICAP CODE

18. SIGNATURE OF PHYSICIAN OR EXAMINER	NAME TYPED OR PRINTED	DATE

19. ADDRESS OF EXAMINING PHYSICIAN *(Typed or printed)*

20. DO YOU HAVE FEDERAL DESIGNATION? ☐ **YES** ☐ **NO**
IF "YES," SPECIFY

☐ **FULL TIME** ☐ **PART TIME** ☐ **FEE BASIS**

TO BE COMPLETED BY SUPERVISOR

21. POSITION TO WHICH INDIVIDUAL WAS ASSIGNED

22. SIGNATURE OF SUPERVISOR	NAME TYPED OR PRINTED	DATE

PHYSICAL HANDICAP CODE INSTRUCTIONS

If the person examined has or has had a handicap which is listed on the back of these instructions, enter the code number in Item No. 17 on the Health Qualification Placement Record.

If more than one handicap applies, enter the one you think most limiting. If none of the handicaps apply, enter the code "00."

Detach these instructions after entering Physical Handicap Code on the Health Qualification Placement Record.

PHYSICAL HANDICAP CODE

00	NO REPORTABLE HANDICAP
10	AMPUTATION - ONE EXTREMITY
11	AMPUTATION - TWO OR MORE EXTREMITIES
20	DEFORMITY OR IMPAIRED FUNCTION - UPPER EXTREMITY
21	DEFORMITY OR IMPAIRED FUNCTION - LOWER EXTREMITY OR BACK
30	VISION - BEST CORRECTED VISION OF POORER EYE NOT MORE THAN 20/200
31	VISION - BEST CORRECTED VISION OF BETTER EYE NOT MORE THAN 20/200
40	HEARING - SOME IN ONE EAR, NONE IN OTHER
41	HEARING - IN BOTH EARS BUT NOT MORE THAN 12/20 IN BETTER EAR WITHOUT USE OF A HEARING AID
42	HEARING - O/20 IN EACH EAR, INCLUDING SPEECH MALFUNCTION
50	TUBERCULOSIS - INACTIVE PULMONARY
51	ORGANIC HEART DISEASE *(Compensated)* - VALVULAR, ARRHYTHMIA, ARTERIOSCLEROSIS, HEALED CORONARY LESIONS
52	DIABETES - CONTROLLED
53	EPILEPSY - ADEQUATELY CONTROLLED
54	HISTORY OF EMOTIONAL OR BEHAVIORAL PROBLEMS REQUIRING SPECIAL PLACEMENT EFFORT
55	MENTALLY RETARDED *(Diagnosis must be certified by appropriate State Office of Vocational Rehabilitation)*